

# Case History

(circle appropriate answers)

What is your main complaint? \_\_\_\_\_

Have you been in an auto accident? **Yes** **No** If yes, describe \_\_\_\_\_

Have you had a personal injury (i.e., a fall)? **Yes** **No** If yes, describe \_\_\_\_\_

Is there pending or possible litigation? **Yes** **No** If yes, who is your attorney? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you ever had similar conditions in the past? **Yes** **No** If yes, what and when? \_\_\_\_\_

What movements /situations aggravate your main complaint? \_\_\_\_\_

What **non-medication** activities make it feel better? \_\_\_\_\_

Is the main complaint getting worse? **Yes** **No** If yes, how? \_\_\_\_\_

Does the main complaint feel: **Constant** **Comes and goes** **Sometimes both**

Is the main complaint worse at night? **Yes** **No** If yes, how? \_\_\_\_\_

Is the pain: **On the surface** **Deep** **Sharp** **Dull** **Throbbing** **Aching** **Electric-like**

**Other:** Please describe \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Has this M.D. treated your complaints? **Yes** **No**

If yes, how? \_\_\_\_\_

Have you ever been to a chiropractor? **Yes** **No** If yes, who and when? \_\_\_\_\_

What therapies were used? \_\_\_\_\_

## List ALL your surgeries (head to foot) and the years when performed:

\_\_\_\_\_ year(s) \_\_\_\_\_  
\_\_\_\_\_ year(s) \_\_\_\_\_  
\_\_\_\_\_ year(s) \_\_\_\_\_  
\_\_\_\_\_ year(s) \_\_\_\_\_

## Do you have or have you had:

Hypertension	Heart conditions	Stroke	Hand / foot / finger / toe numbness / tingling / weakness
Digestive disorders	Female problems	Male problems	Bone problems ADD/ADHD Fainting
Urinary disorders / infections		S.T.D.s	Emotional / mood or other brain syndromes
Breathing problems	Sleeping problems	Diabetes	Allergies Skin problems Cancer

## Medications / vitamins you presently take:

Pain killers \_\_\_\_\_ Muscle relaxers \_\_\_\_\_ Anti-depressants \_\_\_\_\_  
Mood stabilizers \_\_\_\_\_ Hormones \_\_\_\_\_ Blood pressure \_\_\_\_\_  
Cholesterol reducers \_\_\_\_\_ Ibuprofen / aspirin / tylenol \_\_\_\_\_ Birth control / menopause \_\_\_\_\_  
Blood thinner \_\_\_\_\_ Other \_\_\_\_\_

## Social Customs:

Do you use tobacco? **Yes** **No** If yes, what type and how much? \_\_\_\_\_ How many years? \_\_\_\_\_

When did you stop using / smoking? \_\_\_\_\_ How many years did you use before stopping? \_\_\_\_\_

Do you consume alcohol? **Yes** **No** If yes, how much and how often? \_\_\_\_\_

Do you now or have you ever used recreational drugs? **Yes** **No**. If yes, what and when? \_\_\_\_\_

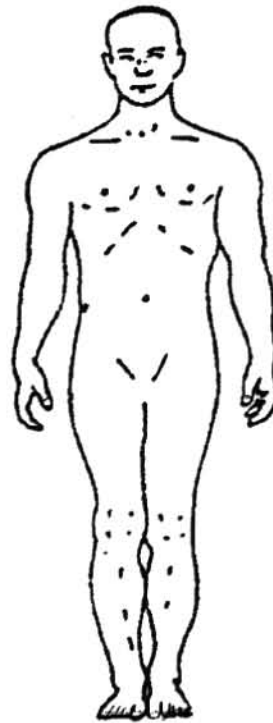
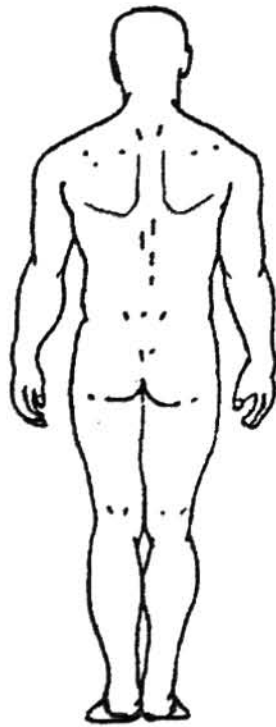
## Family History:

Are your parents alive and well? **Yes** **No**. If no, what were their causes of death and age when deceased? \_\_\_\_\_

Are your brothers and sisters alive and well? **Yes** **No**. If no, what were their causes of death and age when deceased? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Draw on the figures where you feel pain. Mark the most painful as #1, then the second most painful as #2, etc.



Hand  
[ ] right  
[ ] left  
[ ] both



Foot  
[ ] right  
[ ] left  
[ ] both



Name \_\_\_\_\_

Date \_\_\_\_\_



8) In the past 24 hours, how much relief have pain treatments or medications provided?  
Please circle the one percentage that shows how much relief you have received.

0	1	2	3	4	5	6	7	8	9	10
<i>No relief</i>										<i>Complete relief</i>

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

B. Mood

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
<i>Does not interfere</i>										<i>Completely interferes</i>

Source: Pain Research Group, Department of Neurology, University of Wisconsin-Madison. Used with Permission

## Patient Information

Last Name:	First Name:	Middle Initial:	Marital Status: M S W D	Date of Birth:	Sex: M F	Age:	Social Security #:
Home Address:		City:	State:	Zip:	Home Phone #:		
Name of Employer (Patient):		Address:	City:	State:	Zip:	Work Phone #:	
Cell Phone #:				E-mail address:			
Spouse/Partner or Parent Last Name:			First Name:	Middle Initial:	Date of Birth:	Social Security #:	
Name of Employer:		Address:	City:	State:	Zip:	Work Phone #:	
Person Financially Responsible for Health Care Services Received:							
Emergency Contact other than spouse/partner:				Relationship:	Phone #:		

Name of Primary Insurance Company:	Policy #:	Group # and/or Name:
Address of Primary Insurance Company:	City:	State: Zip: Insurance Phone #:
Policy Holders Name:		Relationship to Patient:
Policy Holders Social Security # (if not the same as the policy #):		Policy Holder Date of Birth:

Name of Secondary Insurance Company:	Policy #:	Group # and/or Name:
Address of Secondary Insurance Company:	City:	State: Zip: Insurance Phone #:
Policy Holders Name:		Relationship to Patient:
Policy Holders Social Security # (if not the same as the policy #):		Policy Holder Date of Birth:

I agree that I am responsible for this debt, regardless of my insurance, and I will pay any unpaid balance in full within 60 days of the date of service. I agree to pay 1% per interest per month with a minimum of \$1.00 on the unpaid balance. In the event my account is not paid as I agreed, I agree to pay any collection agency fees in addition to my unpaid balance, in the event that my account is delinquent. In the event that is necessary to commence any legal action to collect this bill, I also agree to pay any additional attorneys fees and court costs. If any portion of this bill, or the provider's services are disputed, I agree to submit to mediation, and will pay the costs of doing so.

**Please sign: I have read the above explanation and agree to pay for services as described.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Informed Consent

Although thorough history and examination are taken and performed by Dr. Smithers to make certain there will be no adverse reactions to spinal manipulation, there is, as in any form of medical intervention, a very remote chance of unfavorable reaction to spinal manipulation. Minor aches and pains, such as muscle spasms, soreness on movement of the neck and back, and general mild limitation of range of motion are infrequent reactions, for spinal manipulation is sought to alleviate these same complaints. Rare (1:30,000) are occurrences of rib fractures (mostly in the elderly population, which unfortunately occur despite a chiropractor's every effort to prevent this from happening), sprained cartilage and joints, and possible nerve irritation. Extremely rare are stroke and disc aggravation to both the neck and lower back as a result of spinal manipulation .

## Stroke Through Neck Manipulation

In the medical journal *Stroke*, 2001, Rothwell claims 1.3 incidents of arterial dissection per 100,000 (one hundred thousand) chiropractic visits. (This is the highest ratio ever purported to be accurate and 60-80 times higher than prior research indicated). In the *Canadian Medical Association Journal*, 2001, Haldeman, Carey *et al* reported 1 incident of arterial dissection per 8,060,000 (8.06 million) office visits to chiropractors, 1 incident of arterial dissection per 5,850,000 (5.85 million) cervical manipulations, or one incident per 1,430 practice years. (The average chiropractor would have to be 3,575 years of age before the first incident occurred). To put this in perspective, general anesthesia is considered to be extremely safe, but has more than 500 times the frequency of unfavorable reactions as compared to neck manipulation, one per 52,000 (fifty two thousand).

Known risk factors are: elderly and female, history of migraine headaches, hypertension, diabetes mellitus, active smoker, currently taking oral contraceptives, and rare genetic traits (i.e., Marfan's Syndrome). The historical screening test to detect possible risk for arterial dissection (George's) is currently deemed inaccurate. It creates false positives inappropriately limiting care. It creates false negatives that give the practitioner a false sense of safety in performing cervical manipulation. In the College of American Neurosurgeons journal, *Spine*, 1999, Haldeman discussed the problem with clinical detection of those who may be at risk. "The [medical] literature does not identify the offending mechanical trauma, neck movement, or type of manipulation precipitating vertebral artery dissection, [thus] does not identify the patient at risk."

Other choices for relief of neck pain and headaches include: 1) analgesics, 2) physical therapy and massage (please note: physical therapists and massage therapist are breaking the law if they attempt to manipulate any joint, for this is only to be performed by licensed physicians – DC, DO, MD), 3) medical doctor, and, 4) doing nothing. Please see the clinic's "Vertebro-basilar Artery Dissection Following Cervical Spinal Manipulation" handout for further information.

## Disc Injury Through Spinal Manipulation

It is a total impossibility to damage an anatomically and physiologically healthy disc through quality chiropractic manipulation, and there are ample research studies to prove this beyond a doubt. It is very difficult to exacerbate an *unhealthy* disc through quality chiropractic manipulation. Unfortunately, there are rare cases of disc herniation that are caused by spinal manipulation.

Most cases of suspect disc damage through spinal manipulation have been where the discs would have herniated all by themselves, whether or not the patient ever had spinal manipulation. The following are identifiable risk factors for neck, thoracic or lumbar disc herniation: 1) arm, chest, and leg tingling, numbness and pain, with or without neck, thoracic/rib, or back pain, 2) previous histories of probable disc damage, prior disc surgeries, 3) frequent episodes of pain and paresthesias (tingling and numbness in the arms, chest, and legs) lasting from several days to weeks in the past, 4) were smokers, 5) were overweight, 6) did little to no exercise, and 7) were not in good physical shape.

Other choices for relief of neck, thoracic and low back pain include: 1) analgesics, 2) physical therapy and massage (please note: physical therapists and massage therapist are breaking the law if they attempt to manipulate any joint, for this is only to be performed by licensed physicians – DC, DO, MD), 3) medical doctor, and, 4) doing nothing.

## Alternative Therapies (acupressure, massage, reflexology, iridology, etc.)

The Back Clinic's experience has been that alternative approaches have very poor outcomes. Be very careful of any advice given by these individuals, for they are not licensed physicians. On the other hand, doing nothing about your complaint is not good medical advice either.

YES. I understand the possible adverse reactions to spinal manipulation and have had opportunity to discuss *any* concerns I have with The Back Clinic staff and/or Dr. Smithers concerning this. I agree to have spinal manipulation performed.

NO. I refuse to have spinal manipulation performed at any level of my spine. Refusing manipulation is strictly your choice, and does not alter quality of care at The Back Clinic.

Patient Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Smithers' initials \_\_\_\_\_

# The Back Clinic

## Financial Policy and Agreement

Thank you for choosing The Back Clinic as your chiropractic healthcare provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to any medical evaluation or treatment. All patients must also complete the information and insurance form before seeing a physician.

1. Each patient is responsible for his/her own bill. We accept cash, check, MasterCard and Visa.
2. Payment of all insurance company co-pays are required at the time medical services are rendered. If you are unable to pay for today's services, we will be happy to reschedule your appointment or charge a \$10.00 billing fee for the co-pay not paid.
3. Patients who have no insurance are required to pay 100% of the bill at the time medical services are rendered. Please discuss financial needs with the front office prior to your appointment so you can better understand the approximate cost and determine how payment will be made.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim. It is your responsibility to know your policy and whether or not the provider you are seeing or the services being rendered are a covered benefit on your insurance plan.
5. If your insurance company has not paid your account in full within 60 days, you will be notified by our office. You may contact your insurance company to determine why payment has not been made. If we have not heard back within 7 working days, we will charge the balance owed to you or your credit card.
6. A \$15.00 fee will be charged on all returned checks.

### **Usual and Customary Rates**

The Back Clinic's rates for chiropractic services reflect the usual and customary rates in the Salt Lake City area. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates chiropractic services.

### **Authorization to Release Information**

I hereby authorize Michael Smithers, DC of The Back Clinic to release all information concerning my medical condition to my insurance carriers) or referring physician(s) if any.

### **Authorization to Pay Benefits**

I hereby assign to The Back Clinic all medical benefits for which I am entitled including Medicare, private insurance, and all other health plans. I hereby instruct my insurance company to pay by check made out and mailed to: Michael Smithers, DC, The Back Clinic, 7084 South 2300 East, Suite 110, Salt Lake City, UT 84121.

If my current policy prohibits direct payment to the physician, then I hereby instruct and direct my insurance company to make out the check to me and mail it directly to The Back Clinic for deposit. This is a direct assignment of my rights and benefits under this policy. I agree to pay any charges for which I am responsible for that my insurance does not cover.

**My signature below states that I agree to the above Financial Policy and Agreement, Usual and Customary Rates, Authorization to Release Information and Authorization to Pay Benefits agreements and they will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.**

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# H.I.P.A.A. Privacy Notice

As providers of medical care *The Back Clinic* (TBC) and *Women's Health Services* (WHS) are committed to keeping and maintaining our patients' medical records as private and confidential information. The following will explain how we as healthcare providers will maintain privacy of your medical records.

- ◆ Personal information is any and all information written or oral provided to us as a provider of medical services.
- ◆ The collection of personal information is done so that we can provide the best medical care as long as the information provided to us is true and complete. Personal information is also collected so that as providers we can bill and collect from the insurance companies. Your medical related information will only be released to the insurance company when it is required to aid in the processing of your medical claims.
- ◆ TBC and WHS collect personal information from the patient as well as from records that are sent from other provider's offices. The records from other provider's offices are sent to our office at the patient's request and therefore become part of the patient's permanent medical record at our office.
- ◆ TBC and WHS reserve the right to discuss a patient's case with any and all providers involved with or potentially involved with the patient's care. This includes, but is not limited to: the referring provider, a provider being referred out to, or a provider that is currently seeing the patient.
- ◆ TBC and WHS will protect the patient's information by having the medical records in the patient's chart and filed in the chart file cabinet when the chart is not in use by either the staff or the provider.
- ◆ If you are needing a copy of your medical records you must do the following:

- ✓ Submit in writing a request stating who the information is being released to and the address or fax number of where the information is to be sent.
- ✓ This request must have an original signature and not be a copy.
- ✓ When making a request please keep in mind that we have a one week turn around for releasing records. To ensure your privacy we will not release records at the time of the request. The records will be sent but it does take one week for the records release to be processed.
- ✓ If you are wanting a copy of your medical records there is a fee for this service. The fee for this service is \$5.00 plus \$.50 per sheet and must be paid at the time the records are picked up. If the records are being sent to another provider we will fax or mail the records to the provider.
- ✓ Our Salt Lake office hours are Monday, Wednesday and Friday from 8:30 am to 5:00 pm. and Tuesday from 9:00 a.m. to 2:00 p.m. We can be reached by either calling (801)9425814 or by appearing in person at 7084 South 2300 East, Suite 110, SLC, UT 84121. Our Wendover office hours are Thursdays from 10:30 am to 6:00 pm. We can be reached by either calling (800)339-5814 or (435)665-2991 or be appearing in person at 391 N Aria Blvd Suite A, Wendover, UT 84083.
- ✓ If you are requesting a revision of your medical record then the request must be submitted in writing to the provider. The request must include the reason for the revision and the address where the response from the provider can be sent. The response to the revision request takes 30 days to process and will be sent to you in writing.

The HIPAA privacy office for TBC and WHS is Michael Smithers, DC. This notice will remain in effect from April 15, 2003. I understand that this HIPAA notice may change at any time and that a copy of the HIPAA notice will be available if I wish to have a copy.

**I have received and read this HIPAA policy and have been given the opportunity to ask any questions that I may have regarding this policy.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Dr's initials** \_\_\_\_\_